2006 Guide To Health Insurance For Delaware Senior Citizens

What you need to know
to make informed decisions about
Medicare, Medigap insurance,
Medicare Advantage,
the new Medicare
prescription drug plans and
long-term care insurance

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What's In This Guide

A Message From Delaware's Insurance Commissioner Matthew Denn

One of the major issues facing Delaware seniors in 2006 is understanding the new Medicare prescription drug plans. The plans are complex and can be confusing, and, although they will help some seniors, they are not right for everybody. Helping Delaware seniors navigate these plans and decide whether to sign up — and, if so, with which plan — has been one of my office's priorities over the last several months. The hard-working ELDER*info* staff, with federal assistance arranged by U.S. Senator Thomas R. Carper, has provided one-on-one assistance to thousands of Delawareans so far, but there are many more seniors who still need help. That's because for those who were already on Medicare, a decision needs to be made by May 15, 2006, which is the end of the initial enrollment period.

To help seniors in the last weeks and days before May 15, my office will be sending a bus we have named the "Reality Check Express" to senior centers and other locations. This bus/mobile office is equipped with internet-connected computers and staffed with trained counselors who will help seniors compare prescription drug plans based on their specific circumstances and decide which — if any — drug plan is right for them. For more information about the new drug plans and the "Reality Check Express," check pages 14 to 17.

This guide also provides you with our annual price comparisons for Medigap insurance, which is private insurance designed to supplement Medicare. When reviewing the rates, keep in mind that changes can be made in the premiums based on your gender and whether or not you smoke. This guide also provides a list of insurance companies that offer Medigap, along with their toll-free telephone numbers.

Once again, we have also provided some helpful information in this guide on long-term care insurance and the companies that offer it in Delaware. Remember that long-term care policies are not standardized like Medigap policies.

I hope that you find this guide useful in helping you decide what is right for you and your loved ones. If I or my staff can be of help to you, please call 1-800-336-9500 or visit us at www.state.de.us/inscom on the web.

Sincerely,

Matthew Denn
Insurance Commissioner

About Original Medicare, Medigap, And Other Health Insurance Options

Original Medicare

Medicare is a federal health insurance program for people 65 years of age or older, people of any age with permanent kidney failure, and certain disabled people under age 65. The Centers for Medicare & Medicaid Services, part of the U.S. Department of Health and Human Services, manages Medicare. The Original Medicare program has two parts – Hospital Insurance, commonly known as Part A, and Medical Insurance, known as Part B.

Part A: Part A helps pay for inpatient hospital care and certain follow-up care, such as skilled nursing and home health. For most people, Part A is premium-free because you or your spouse paid Medicare taxes for at least 10 years while you were working. If you have less than 10 working years' credit, you may be eligible to purchase coverage and should contact the Social Security Administration for information.

Part B: Part B helps pay for doctors, outpatient hospital care, x-rays, laboratory tests and certain types of medical equipment, such as wheelchairs. If you are eligible for premium-free Part A, you are automatically eligible to purchase Part B. Part B is voluntary and costs $88.50 per month in 2006.

Part B General Enrollment Period: If you didn't take Part B when you were first eligible for Medicare, you may only sign up during the General Enrollment Period, which runs from January 1 through March 31 of each year. Your Part B coverage then becomes effective July 1 and the monthly Part B premium may be higher. The Part B premium increases 10 percent for each full 12-month period that you could have had Part B but did not take it. You will have to pay this extra amount as long as you have Medicare Part B.

Part B Special Enrollment Period: If you didn't take Part B because you or your spouse currently works and has group health coverage through your current employer or union, you can sign up for Part B during the Special Enrollment Period. You can sign up at any time while you are covered under the group plan, or within 8 months of the date your employer or union group coverage ends or when the employment ends (whichever is first). Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums.

Out-of-Pocket Costs: Medicare does not cover all of your health care costs. Your "out-of-pocket" costs will include your monthly Part B premium, as well as deductibles and the Original Medicare plan coinsurance and outpatient co-payment amounts. Additionally, Medicare does not cover routine eye care, hearing aids, most dental care, dentures, routine foot care or care received in a foreign country. Prescription drugs are now covered by separate Medicare drug plans (see below).

Medicare Prescription Drug Plans (Part D)

Beginning January 1, 2006, Medicare prescription drug plans are now available. The initial sign-up period ends May 15, 2006. After that date, if you were eligible to sign up for a Medicare prescription drug plan during the initial enrollment but did not, you will have to pay more if you sign up for a Medicare drug plan in the future. If you were eligible during the initial enrollment period and do not sign up, you will only be able to enroll between November 15 and December 31 of each year.

From now on, when you turn 65 and become eligible for Medicare, you may sign up for a Medicare drug plan three months before and three months after your 65th birthday. If you do not sign up during this period, you may only be able to sign up between November 15 and December 31 of each year.

For much more information about Medicare prescription drug plans (also known as Part D), see pages 14 to 17 in this guide.

Medigap

"Medigap" is health insurance sold by insurance companies to help fill the "gaps" in the Original Medicare plan. Medigap insurance policies pay most, if not all, of the Original Medicare plan coinsurance and/or co-payment amounts. Medigap policies may also provide coverage for the original Medicare plan deductibles.

Medigap insurance consists of 12 standardized plans, A-L. Please review pages 8 and 9 to learn about Medigap plans.

Some of the Medigap plans pay for services not covered by Medicare, including preventive care not covered by Original Medicare or emergency care while traveling in a foreign country.

When describing the benefits of each of the Medigap plans, insurance companies must use the same format, language, and definitions. They are also required to use a uniform chart and outline of coverage to summarize the benefits in each plan. These requirements make it easier for you to compare policies. As you shop for a Medigap policy, keep in mind that each company's products are alike, so they are competing on service, reliability and price.

All standard Medigap policies are guaranteed renewable. This means that the insurance company must allow you to renew your Medigap policy, unless you do not pay the premiums.

A list of the companies licensed to sell Medigap insurance in Delaware, the plans each company offers, the approximate yearly premium for each plan, and the telephone number for each insurance company can be found on pages 10 to 13.

Medigap and Open Enrollment Guarantees: During the first six months you are age 65 and enrolled in Part B, you can buy the policy of your choice regardless of whether you had enrolled in Part B before you were 65. During these six months, you cannot be refused a policy because of your disability or for other health reasons, and you cannot be charged more than other applicants. Once you enroll in Part B, the six-month Medigap open enrollment period starts and cannot be extended or repeated.

A waiting period of up to six months may be imposed for coverage of a pre-existing condition. However, if you buy a Medigap policy during your open enrollment period and you had previous health coverage that qualifies as "creditable coverage," the insurance company must reduce the waiting period for pre-existing conditions by the number of months of creditable coverage you had.

Medicare Savings Program

For certain low-income individuals entitled to Medicare Part A, the Medicare Savings Program may pay some or all of Medicare's premiums, deductibles and coinsurance. The programs that help pay Medicare's premiums are called the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, and the Qualifying Individual (QI-1) program. For eligibility requirements, please contact ELDER*info* at 1-800-336-9500.

Military Retirees

To serve the medical needs of military retirees, their family members, and their survivors who are age 65 and older, there is TRICARE for Life. For eligibility requirements, please contact the Defense Enrollment Eligibility Reporting System (DEERS) at 1-800-538-9552 or TRICARE for Life at 1-888-363-5433. You may also obtain information about TRICARE on the web at www.tricare.osd.mil.

Veterans Benefits and Medicare

Veterans may receive services through the Veterans Administration health care system *and* Medicare. If you are receiving some of your care through the Medicare program, you can still obtain other services through the VA. You do not have to drop your Medicare coverage to receive VA health care benefits. For some veterans, the health care

they receive is free. Other veterans may be responsible for making co-payments for services and supplies they obtain, including medications. These co-payments are not reimbursable by Medicare.

When you receive care through the VA, it is important for you to give information about any health care coverage you may have, including coverage provided through your spouse. The VA will submit claims to insurance carriers to recover the costs of providing care for medical conditions that are not "service connected" by the VA. Although the VA cannot currently bill Medicare for your services, any Medicare supplemental insurance you may have can be billed for that portion of the costs that the supplemental policy covers.

For more information about your specific out-of-pocket costs, contact any VA health care facility. Questions regarding whether the VA or Medicare should pay for your doctor or other services covered under Medicare Part B, contact your Medicare carrier. If you have questions about whether the VA or Medicare should pay for hospital or other services covered under Medicare Part A, ask the provider of services to check with the Medicare Intermediary. You may contact the VA Regional Office at 1-800-827-1000 or the VA Medical Center, Eligibility Department at 1-800-461-8262 ext. 5212

Employer Group Health Insurance

Group Health Coverage for the Currently Employed: When you reach age 65, you may still have private insurance through your or your spouse's current employer or union membership. If you have this kind of coverage, find out if it can be continued after you retire. Check the price and the benefits, including benefits for your spouse. Group health coverage provided by employers and unions is subject to rules issued by both the Department of Labor and the Internal Revenue Service.

Group Health Coverage for Retired Employees: Group health coverage continued after retirement usually has the advantage of having no waiting period or exclusions for pre-existing conditions. Coverage is usually based on group premium rates, which may be lower than the premium rates for policies you buy yourself. Retiree insurance that is not a Medigap policy does not have to follow the rules for Medigap policies, but under some circumstances must follow the rules of the Department of Labor. These plans have their own rules and might not fill the gaps in Medicare. While retiree insurance may not offer the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care. Keep in mind that the retirement coverage provided by the employer or union may have caps or limits on benefits. If you are not sure how your plan works with Medicare, call the plan's benefit office and ask how the plan pays when you have Medicare.

A word of caution: If you give up your employer-based health coverage, you probably won't be able to get it back. Contact your employee benefits office for more information.

Retirement Health Plans and Medigap

You may buy a Medigap policy even if it duplicates your retiree insurance benefits. The Medigap policy must pay full benefits even if the retiree insurance also pays for the same service. Your retiree insurance may, however, contain a coordination of benefits clause. If it does, it may not pay duplicate benefits.

Other Insurance Options

There are several types of "limited" or "supplemental" insurance plans available that are sold to Medicare beneficiaries. These include policies that pay a certain amount only for a specific occurrence, such as a particular disease, hospitalization, accidental injury, surgical expense, etc. Because the benefits provided by these plans are limited, this type of insurance should not be purchased in lieu of Medigap insurance, Medicare managed care plans or comprehensive health coverage. Therefore, when considering the purchase of a limited insurance plan, be aware that the plan may pay benefits in addition to those

already provided to you by Medicare, Medigap or a Medicare Managed Care Plan.

Prescription Assistance Program

The Delaware Prescription Assistance Program, (DPAP) is funded by tobacco settlement money and provides a $2,500 prescription benefit per year for low-income seniors or low-income disabled persons. To determine if you are eligible for assistance, please contact DPAP at 1-800-996-9969.

Consumer Protections

If you lose your health plan coverage under certain circumstances, you will have a right to purchase a Medigap policy (Plan A, B, C , F, K or L) as long as you apply within 63 days of losing your coverage. Special protections apply with regard to pre-existing conditions and for the disabled. The circumstances include:

- Your Medicare Managed Care Plan or Private Fee-for-Service Plan terminates or stops providing care in your area.
- You move outside the plan's service area.
- You leave the plan because it failed to meet its obligations to you.
- You were in an employer health plan that terminated coverage.
- You drop your Medigap policy to join a Medicare Advantage plan for the first time and you leave within one year of joining.
- You join a Medicare Advantage plan when you first become eligible for Medicare at age 65 and you leave the plan within one year.

The terminating plan is required to provide you with written proof of coverage as evidence of continuous insurance for enrolling in another plan. Do not destroy or lose this notification.

Tips From The Commissioner

A Focus On Consumers

Insurance Commissioner Matthew Denn took office in January 2005 with a goal of improving the office's service to, and protection of, Delawareans.

He has created new positions to answer questions and help with problems that Delaware residents may face with their insurance. The Insurance Commissioner's Office can be reached at 1-800-282-8611.

The Commissioner's website provides updated news and information about insurance issues affecting Delawareans. An online complaint form provides an easy method for you to get timely answers to your insurance questions.

Commissioner Denn hopes that you will visit the website and take advantage of what it has to offer at www.state.de.us/inscom.

ELDER*info*

Just for Delawareans with Medicare, the Insurance Commissioner's ELDER*info* program provides Medicare beneficiaries with information related to all types of health insurance.

To contact ELDER*info*, call 1-800-336-9500 or go to www.state.de.us/inscom/eldindex.htm.

Medicare Advantage Plans

Medicare Advantage Plans are designed to provide more health care coverage choices and different health care benefits than Original Medicare or the old Medicare+Choice Plans.

Medicare Advantage Plans are offered by private companies that sign a contract with Medicare. Medicare Advantage Plans provide Medicare-covered benefits to Medicare members through the plan, and may offer prescription drug benefits as well as extra benefits that Medicare doesn't cover, such as vision or dental services.

If you join one of these plans, you generally get all your Medicare-covered health care through that plan and will use the health care card that you receive from your Medicare Advantage Plan.

To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium of $88.50 in 2006 to Medicare. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan. And the plan may have special rules to follow.

If you're in a Medicare Advantage Plan, you generally don't need a Medigap policy because Medicare Advantage Plans generally cover many of the same benefits that a Medigap policy would cover.

Types of Medicare Advantage plans currently available in Delaware include:

- **Private Fee-For-Service Plans**—You can see any doctor that accepts the plan's payment terms. The private company, not Medicare, negotiates with providers to decide how much it will pay and what you pay for the services you receive. No referrals are necessary. Currently there are two Private Fee-For-Service Plans available in Delaware: Sterling Insurance Company, 1-888-858-8572; or Secure Horizons Direct, 1-800-776-887.

- **PPOs**—A new option available to Delawareans this year, Medicare Preferred Provider Organization (PPO) Plans allow you to see any doctor, but it costs less to see doctors in the plan's network. Some plans don't require a referral to see a specialist. In 2006, three different Medicare PPO Plans are available to Delaware residents from Aetna Life Insurance Company, 1-800-832-2540.

- **Medicare Specialty Plans** — These provide all Medicare health care for certain people with special needs who have Medicare. In Delaware, a Medicare Specialty Plan is available from United Healthcare Insurance, 1-800-393-0395.

Details about the Medicare Advantage Plans available in Delaware can also be found online at www.medicare.gov.

In some states, there are Medicare Health Maintenance Organization (HMO) Plans available, however there are currently no companies offering Medicare HMO Plans in Delaware.

Joining Or Switching Plans

Sometimes, people with Medicare decide to join a plan or switch to another plan. For example, a person who has the Original Medicare Plan might decide to switch to a Medicare PPO. Or, a person might decide to switch from a Medicare PPO to a Private Fee-For-Service.

Compare Original Medicare and the Medicare Advantage Plans available in Delaware. Once you have decided which plan you want, contact the plan you are interested in for enrollment information. For example, some plans will send you an enrollment form. Fill out the form and mail it to the plan, or give it to the plan representative. You can get help filling out this form. You will get a letter from the plan telling you when your coverage begins.

You can't call a Medicare Advantage Plan or other Medicare Health Plan to join over the telephone, unless you are switching to another plan offered by the same company, and the company offers that option.

You can keep a Medigap policy if you join a Medicare Advantage Plan. However, you will have to keep paying your premiums and you may get little or no benefit from it while you are in a Medicare Advantage Plan. If you join a Medicare Advantage Plan, you will have to pay co-payments and deductibles. You can call ELDER*info* at 1–800-336-9500 if you need help deciding whether to keep your Medigap policy. If you drop your Medigap policy, you may not be able to get it back, except in certain situations.

If you join a Medicare Advantage Plan or other Medicare Health Plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your plan coverage. Talk to your employer or union benefits administrator about the rules that apply. Remember, if you drop your employer or union coverage, you may not be able to rejoin it later.

Generally, if you join a Medicare Advantage Plan, you can only change plans under certain circumstances. You can choose to switch your current plan during a period from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can switch your plan at other times. After you request to switch, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

You can switch your Medicare plan in one of three ways:

- Join another Medicare plan
- Write or call your plan
- Call 1-800-MEDICARE (1-800-633-4227)

If you want to switch from a Medicare Advantage Plan to Original Medicare and buy a Medigap policy, you need to contact your current plan or call 1-800-MEDICARE (1-800-633-4227). Simply signing up for the Medigap policy won't end your Medicare Advantage Plan coverage.

The Standard Medigap Plans Offered By Insurance Companies

Plan A

Consists of these basic benefits:

- Coverage for the Part A coinsurance amount ($238 per day in 2006) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($476 per day in 2006) for each of Medicare's 60 non-renewable lifetime hospital in-patient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional in-patient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System (PPS) or under another appropriate standard of payment for hospitals not subject to the PPS. Beneficiaries may be responsible for payment when Medigap hospital benefits are exhausted.
- Coverage under Medicare Part A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year, unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges for outpatient mental health service after $124 deductible is met).

Plan B

Includes the basic benefits under Plan A plus:

- Coverage for the Medicare Part A in-patient hospital deductible ($952 per benefit period in 2006).

Plan C

Includes the benefits under Plan A and Plan B plus:

- Coverage for the Medicare Part B deductible ($124 per calendar year in 2006).
- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Plan D

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery.

Plan E

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for such things as a physical examination, serum cholesterol screening, thyroid function testing, etc.

Summary Of Medigap Plans A—J

	A	B	C	D	E	F/F*	G	H	I	J/J*
Basic Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Deductible			✓			✓				✓
Part B Excess (%)						100%	80%		100%	100%
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Preventive Care Not Covered By Medicare					✓					✓

*Plans F and J also have a high deductible option plan. The high deductible plans offer the same benefits as Plans F and J after one has paid a calendar year $1,790 deductible. Benefits will not begin until out-of-pocket expenses exceed $1,790. The out-of-pocket expenses include Medicare deductibles for Part A and Part B but do not include separate prescription drug deductible or foreign travel emergency deductible.

Plan F
Includes the benefits under Plan A and Plan B plus:
- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- Coverage for the Medicare Part B deductible ($124 per calendar year in 2006).
- Coverage for 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Plan G
Includes the benefits under Plan A and Plan B plus:
- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- Coverage for 80% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery.

Plan H
Includes the benefits under Plan A and Plan B plus:
- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Plan I
Includes the benefits under Plan A and Plan B plus:
- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- Coverage for 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery.

Plan J
Includes the benefits under Plan A and Plan B plus:
- Coverage for the skilled nursing facility care coinsurance amount ($119 per day for days 21 through 100 per benefit period in 2006).
- Coverage for the Medicare Part B deductible ($124 per calendar year in 2006).
- Coverage for 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for such things as a physical examination, serum cholesterol screening, and thyroid function testing.

Plans K & L
With Different
Cost-sharing For Items And Services Than
Plans A-J

Plan K
- 100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end.
- 50% of Medicare-eligible expenses for the first three pints of blood.
- 100% Part B coinsurance for Part B preventive services.
- 50% skilled nursing facility coinsurance
- 50% Part A deductible.
- 50% hospice cost-sharing for all Medicare Part A eligible expenses and respite care.
- Plan pays 100% of Medicare co-payments, coinsurance and deductibles for the rest of the calendar year after a $4,000 out-of-pocket annual limit is reached. The limit does not include expenses that exceed Medicare-approved amounts.

Plan L
- 100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end.
- 75% of Medicare-eligible expenses for the first three pints of blood.
- 75% Part B co-insurance, except 100% coinsurance for Part B preventive service.
- 75% skilled nursing facility co-insurance.
- 75% Part A deductible.
- 75% hospice cost–sharing for all Medicare Part A eligible expenses and respite care.
- Plan pays 100% of Medicare co-payments, coinsurance and deductibles for the rest of the calendar year after a $2,000 out-of-pocket limit is reached. The limit does not include expenses that exceed Medicare-approved amounts.

2006 Rates For Med

This chart shows the annual premiums, based on age, offered by private insurance companies providing Medigap information agency. Rating key below. For companies that offer coverage to disabled persons under age 65, rates

Medigap Plan ▶			A					B					C				
▼Company	Rating	I,C,A	65	70	75	80	<65 DIS	65	70	75	80	<65 DIS	65	70	75	80	<65 DIS
American Progressive Life and Health	B++	A															
Insurance Co of NY 1-800-664-6494																	
American National Life Insurance Co.	A	A	983	1100	1285	1479		1232	1379	1611	1854		1398	1564	1828	2103	
1-800-899-6520																	
Bankers Fidelity Life Insurance Co.	B++	I	866	969	1055	1107		1396	1566	1773	1868	2056	1758	1934	2207	2363	
1-800-241-1439																	
Bankers Life and Casualty Co.	B++	A	992	1127	1316	1560	1560	1505	1777	2147	2624	2624	1964	2354	2898	3623	3623
1-800-621-3724																	
Blue Cross Blue Shield of Delaware	NR	A	824	1119	1389	1600	1989	953	1293	1606	1850	2300	1337	1815	2254	2596	3228
1-800-633-2563																	
Central Reserve Life Insurance Co.	B+	A	1772	1983	2286	2502		1866	2088	2407	2637		2203	2470	2842	3114	
1-800-734-3942																	
Combined Insurance Co. of America	A	I	1601	1716	2040	2305		1845	1934	2299	2599		2277	2387	2837	3207	
1-800-544-5531																	
Conseco Health Insurance Co.	B++	A	1247	1709	1905	1964		1475	2055	2350	2495		1812	2465	2870	3169	
1-800-541-2254																	
Continental General Insurance Co.	B+	A	1516	1835	2116	2317		1551	1878	2163	2370		2143	2598	2989	3277	
1-877-291-5434																	
Genworth Life and Annuity Assurance Co.	A+	A	1105	1204	1327	1456		1187	1322	1477	1631		2339	2564	2819	3080	
1-877-825-9337																	
Globe Life and Accident Ins. Co.	A+	A	771	1031	1098	1103		1131	1424	1624	1640		1295	1588	1870	1965	
1-800-801-6831																	
Guarantee Trust Life Insurance Co.	B+	A	1081	1273	1463	1636		1481	1738	1990	2226		1991	2338	2680	2995	
1-800-338-7452																	
Humana	A-	A	1833	2042	2354	2604		1934	2154	2484	2747		2243	2497	2880	3196	
1-800-866-0581																	
Lincoln Heritage Life Insurance Co.	B++	A	1161	1310	1524	1671		1510	1713	2019	2247		1810	2022	2369	2627	
1-800-438-7180																	
Standard Life and Accident Insurance Co.	A	A	1609	1669	1950	2244		2017	2093	2445	2814		2321	2408	2813	3237	
1-888-350-1488																	
State Farm Mutual Auto Ins. Co.	A++	C	1061	1337	1549	1740		1408	1774	2056	2309		1600	2016	2336	2624	
(302) 731-9242 or (302) 674-1158																	
Sterling Life Insurance Co.	A-	A	1500	1716	1874	1982	2800	1754	2050	2298	2549		1979	2317	2603	2900	
1-800-688-0010																	
United American Insurance Co.	A+	I,A	1577	1738	1738	1738	2747	1807	2393	2595	2622	3479	2034	2687	2950	3099	
1-800-331-2512																	
United Healthcare Ins. Co (AARP)	A+	C	958	1422	1422	1422		1196	1772	1772	1772		1385	2049	2049	2049	
1-800-523-5800																	
USAA Life Insurance Company	A++	A	908	1004	1081	1151	908^	1385	1536	1646	1742	1385	1824	2011	2162	2273	1824
1-800-531-8000																	

Rating Key

A++ and A+ = Superior
A and A- = Excellent
B++ and B+ = Very Good
B and B- = Fair
C = Weak
u = Under review
NR = No Rating Available
Ratings accurate as of March 2006. For the most current rate information, please visit www.ambest.com.

I, C, A

I = Issue Age premium, based
C = Community Rated premium
A = Attained Age premiums, m

igap Insurance Plans

insurance in Delaware. “Rating” is an evaluation of the company by A.M. Best, an independent rating and are in the “<65 DIS” column. Not all companies offer all plans. See below for column titled “I, C, A”.

D					E					F					High Deductible F					G				
65	70	75	80	<65 DIS	65	70	75	80	<65 DIS	65	70	75	80	<65 DIS	65	70	75	80	<65 DIS	65	70	75	80	<65 DIS
Call for 2006 rates and plans																								
1103	1234	1442	1660		1031	1153	1346	1549		1386	1551	1812	2085							1095	1226	1432	1648	
1434	1608	1815	1970							1981	2132	2377	2510		1189	1279	1427	1506		1320	1425	1638	1765	
1647	1974	2430	3038		1496	1778	2162	2667		1439	1724	2123	2654	2654	449	536	641	769	769	1379	1653	2035	2544	
1224	1661	2063	2376	2955						1368	1857	2306	2656	3303										
1728	1934	2229	2443		1641	1833	2108	2308		2149	2407	2772	3035		766	858	989	1083		1742	1950	2245	2460	
2026	2141	2556	2882							2396	2511	2985	3375											
1489	2100	2472	2758		1462	2061	2425	2700		1701	2327	2725	2993							1428	2026	2394	2660	
1636	1978	2280	2499		1345	1627	1874	2055		1989	2408	2773	3037		483	584	673	738		1701	2062	2373	2600	
1468	1626	1789	1950							2352	2591	2904	3058											
										1304	1598	1883	1980											
1277	1501	1721	1924							2086	2456	2822	3160							1224	1437	1646	1841	
										2258	2515	2900	3208		892	993	1146	1267						
1560	1772	2095	2339							1866	2094	2441	2707											
1523	1580	1846	2124		1439	1493	1744	2007		2335	2422	2830	3257		643*	667*	779*	896*		1530	1588	1855	2134	
															*Will decrease Sept. 06									
										1616	2036	2359	2650											
										1987	2327	2614	2911											
1929	2572	2835	2985							2753	3023	3143	3225		788	1035	1151	1219		2637	2903	3024	3105	
1304	1930	1930	1930		1304	1930	1930	1930		1394	2062	2062	2062							1313	1944	1944	1944	
1416	1567	1687	1789	1416						1559	1718	1846	1962	1559										

on the age at which you purchased your policy and will not increase simply because you age. Premiums may increase due to inflation.
ns, meaning all policyholders pay the same premium regardless of age.
eaning the price of the policy will increase as you get older. Most companies that use attained age pricing raise the price every year.

2006 Rates For Medigap Insurance Plans (Continued)

Please see chart explanation on pages 10 and 11.

Plan ▶	H					I					J					High	K				
▼Company	65	70	75	80	<65 DIS	65	70	75	80	<65 DIS	65	70	75	80	<65 DIS	Deductible J	65	70	75	80	<65 DIS
Amer. Progr.	Call for 2006 rates and plans															None Offered In Delaware					
Amer. Nat.																					
Bankers Fid.																					
Bankers Life											1419	1751	2162	2697			668	824	1018	1269	
Blue Cross																					
Central Res.																					
Combined																					
Conseco																					
Continental																					
Genworth																					
Globe Life																					
Guarantee																					
Humana																					
Lincoln																					
Standard																					
State Farm																					
Sterling																					
United Amer.																					
UnitedHealth	1147	1699	1699	1699		1156	1713	1713	1713		1421	2102	2102	2102			670	1000	1000	1000	
USAA																					

Notes

L				
65	70	75	80	<65 DIS
962	1186	1465	1827	
964	1432	1432	1432	

Tips From The Commissioner

- You only need one Medigap policy.
- The lowest price is not always the best deal. If the policy is priced too low, you could be hit with a big price hike in the future.
- Don't be fooled by sales hype. All plans are identical from one insurance company to another - and must be labeled with the letters A, B, C, D, E, F, G, H, I , J, K or L.
- Your premiums are not guaranteed for life. They may (and probably will) go up.
- Medical conditions you had before purchasing the policy can be excluded, but not for longer than six months.
- All policies have a 30-day free look period. During this time, you may review the policy, cancel, and get a full refund.
- Pay by check. Make the check out to the insurance company, not the agent. Never pay with cash.
- If you are switching policies, do not cancel your current plan until you have received your new policy.

Medicare Prescription Drug Plans

On January 1, 2006, new Medicare prescription drug plans became available to people with Medicare. Insurance companies and other private companies offer these drug plans. All people with Medicare are able to enroll in plans that cover prescription drugs.

The new Medicare drug plans are complex and can be confusing. The decision of whether to sign up for a Medicare drug plan should only be made after considering your individual circumstances and evaluating whether the Medicare drug plan provides benefits that are better, about the same or less than any prescription drug coverage you may already have.

In 2006, May 15 is the deadline for the initial enrollment period for the Medicare drug plans. If you are eligible to sign up for a Medicare prescription drug plan during the initial enrollment and decide not to, you will likely be charged more if you decide to sign up at some point in the future. After May 15, you may only be able to sign up for Medicare drug plans between November 15 and December 31 of each year.

How They Are Supposed To Work

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if you join you will pay a monthly premium (the average is about $32 in 2006) and pay a share of the cost of your prescriptions. Costs will vary depending on the drug plan you choose.

Drug plans vary in what prescription drugs are covered, how much you have to pay, and which pharmacies you can use. All drug plans have to provide at least a standard level of coverage set by Medicare. However, some plans offer more coverage and additional drugs for a higher monthly premium. When you join a drug plan, it is important for you to choose one that meets your specific prescription drug needs.

Plans vary, but in general, this is how they work:

- You will choose a prescription drug plan and pay a monthly premium (2006 average premium is about $32 a month).
- You will pay the first $250 of your drug costs per year.
- Medicare then will pay 75 percent of drug costs between $250 and $2,250 a year in drug spending. You will pay only 25 percent of these costs.
- You will pay 100 percent of the drug costs above $2,250 until you reach $3,600 in out-of-pocket spending in a year.
- Medicare will pay about 95 percent of your drug costs after you have spent $3,600 in a year.

Some prescription drug plans may have additional options to help you pay the out-of-pocket costs.

Frequently Asked Questions About The New Medicare Prescription Drug Plans

When can I join a Medicare prescription drug plan? If you already had Medicare Part A and/or Part B, you are able to join a Medicare prescription drug plan during the initial enrollment period between November 15, 2005, and May 15, 2006. After that, in general, you will only be able to join or change plans once each year between November 15 and December 31.

Even if you don't use a lot of prescription drugs now, Medicare says that you should consider joining a plan now if you are eligible during the initial enrollment period. If you don't join a plan by May 15, 2006, and you don't have a drug plan that covers as much or more than a Medicare prescription drug plan, you will have to pay more if you decide to join later.

If you become eligible for Medicare by turning age 65 after February 2006, you are able to join during the period that starts three months before the month you turn 65 and ends three months after

the month you turn 65. If you join during the three months before you turn 65, your drug coverage will begin the first day of the month of your birthday. If you join the month you turn 65 or the three months after, your coverage will begin the first day of the month after the month you join.

What if I can't pay for a Medicare prescription drug plan? Some people with an income at or below a set amount and with limited assets (including your savings and stocks, but not counting your home) will qualify for extra help. The income amount in 2006 is $14,700 for a single person or $19,800 for a married couple. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions. The level of extra help will be based on your income and assets. Many people who automatically qualified for extra help should have received a letter in 2005. To find out if you qualify for extra assistance, call the federal Social Security Administration at 1-800-772-1213 or go to www.socialsecurity.gov online. There is no risk to call or apply.

Do Medicare prescription drug plans work with all types of Medicare health plans? Yes. There are Medicare prescription drug plans that add coverage to Original Medicare. These plans are offered by insurance companies and other private companies. There are also some drug plans that are a part of Medicare Advantage Plans in some areas.

What if I already have prescription drug coverage from a Medigap supplemental insurance policy? If you have a Medigap policy with drug coverage, you should have received a detailed notice from your insurance company telling you whether or not your policy covers as much as or more than a Medicare prescription drug plan. This notice will explain your rights and choices.

What if I have prescription drug coverage from an employer or union? If you have prescription drug coverage from an employer or union, you should have received a notice from your employer or union that tells you if your plan covers as much as or more than a Medicare prescription drug plan.

If your employer or union plan covers as much as or more than a Medicare prescription drug plan, you can:

- Keep your current drug plan. If you join a Medicare prescription drug plan later your monthly premium won't be higher (no surcharge), *or*
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your employer or union drug plan back.

If your employer or union plan covers less than a Medicare prescription drug plan, you can:

- Keep your current drug plan and join a Medicare prescription drug plan to give you more complete prescription drug coverage, *or*
- Just keep your current drug plan. But, if you join a Medicare prescription drug plan later, you will have to pay more for the monthly premium, *or*
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your employer or union drug plan back.

How Do I Decide If I Should Sign Up?

Which Medicare prescription drug plan to sign up for — or whether to sign up at all — is a decision that is based on your individual and specific circumstances. Before you make a decision, you need to find out the following information:

- If you have drug coverage now, does it cover at least as much as Medicare prescription drug coverage? Your current plan can tell you if it does.
- If you have drug coverage now, should you keep it?
- How would Medicare prescription drug coverage affect your out-of-pocket costs?

- Does a Medicare drug plan available in Delaware cover the drugs you need?
- Would you qualify for help paying for your prescription drug costs if you join a Medicare drug plan?
- If you wait to join a Medicare drug plan, will your premium be higher because you have to pay a penalty?
- Do you spend part of each year in another state? This may be important if the drug plan you are considering requires you to use certain pharmacies.

Drug Plans Available In Delaware

Different drug plans are available in different states. There are almost 50 plans available in Delaware in 2006. To find the names and details of plans available in Delaware, go to www.medicare.gov on the web or by calling 1-800-MEDICARE (TTY users should call 1-877-486-2048) or call the Delaware Insurance Commissioner's ELDER*info* office at 1-800-336-9500.

Things To Look For In A Plan

Consider the following tips from the staff of ELDER*info*, a program in the Delaware Insurance Commissioner's Office that has helped thousands of Delaware seniors compare Medicare prescription drug plans and decide whether to join.

Drug list: Also known as a "formulary," each Medicare drug plan will have a list of prescription drugs that it will cover. Plans may cover both generic and brand-name prescription drugs. These drugs must be approved by the Food and Drug Administration as safe and effective. Make sure your prescription drugs are on the plan's formulary.

Tier levels: There are different levels of co-payments for drugs in the plans. Tier 1 consists of generic drugs that will cost you the least amount. Tier 2 drugs are preferred brand-name drugs that will cost you more than Tier 1 drugs. And Tier 3 is made up of non-preferred brand-name drugs that will cost your more than Tier 1 and Tier 2 drugs. Make sure you know which tier your drugs fall into.

Step therapy: Step therapy is a type of prior authorization. With step therapy, in most cases you must first try certain less expensive drugs that have been proven effective for most people with your condition before you can get a more expensive brand-name drug covered. However, if you have already tried the similar, less expensive drugs and they didn't work, or if your doctor believes that because of your medical condition it is medically necessary for you to be on a step-therapy drug, he or she can contact the plan to request an exception. If your doctor's request is approved, the step-therapy drug will be covered. When evaluating Medicare drug plans, check to see if any of your drugs fall into this category.

Quantity limits: For safety and cost reasons, some plans may limit the quantity of drugs that they cover over a certain period of time. Check to see if any of your drugs has a limit.

$0 co-payment for generic drugs: The co-payments for generic drugs may increase from $0 once your drug costs reach a certain dollar amount. Ask any plan that you are considering what this drug cost limit is and what the new co-payment for generic drugs will be once that limit is reached.

How Do I Sign Up?

To sign up for a Medicare prescription drug plan, you can:

- Sign up online at www.medicare.gov
- Call 1-800-MEDICARE
- Call the company whose plan you want to choose; or
- Call ELDER*info* in Delaware at 1-800-336-9500

Once you join a plan, the company will send you a membership card, member handbook, drug list pharmacy provider directory, and the complaint and appeals procedures.

For Help or More Information

Many Delaware seniors have needed help understanding which Medicare prescription drug plan is best for them, whether they qualify for financial assistance, or whether they should sign up for a plan at all.

Wherever you call for help, you will need to have on hand: the full name of any prescription drug you currently take; whether it is liquid, tablet or capsule; the strength and dosage (for example, 100 mg, two times a day); the number of doses in each prescription; and the cost of the prescription.

Counseling and information is available from:

- **Medicare.gov:** This website maintained by the federal government allows you to input your specific prescription and dosages in order to compare the plans that are available in Delaware based on your specific information.

- **1-800-MEDICARE:** Call the federal government's Medicare hotline with your prescription drug information at hand and a representative will go through the plan comparison process over the phone.

- **Delaware's ELDER*info* Program:** The Insurance Commissioner's service for people with Medicare can provide you with free counseling on whether a Medicare drug plan would save you money and which one may be most suited for you. The statewide toll-free number is 1-800-336-9500.

In April and May 2006, prior to the May 15 deadline for the initial enrollment period, the Insurance Commissioner will sponsor the "Reality Check Express," a bus that will visit senior centers and other locations around the state to provide counseling and internet drug comparisons. See the box at right for more information.

Come Find Out If Medicare Prescription Drug Plans Are Right Or Wrong For You

In April and May 2006, the "Reality Check Express" — a mobile office equipped with internet-connected computers and trained staff — will make stops at senior centers and other locations around Delaware to counsel Delaware seniors and others with Medicare on prescription drug plan choices.

This effort is being sponsored by Insurance Commissioner Matthew Denn in the weeks and days leading up to May 15, which is the end of the initial Medicare prescription drug plan enrollment period.

Dates and times for the "Reality Check Express" stops will be advertised in Delaware weekly newspapers and will be posted on the Insurance Commissioner's website at www.state.de.us/inscom. You may also call ELDER*info* at 1-800-336-9500 before May 15 to find out when the "Reality Check Express" will be near you.

Commissioner Denn may also offer the "Reality Check Express" during the first annual open enrollment between November 15 and December 31, 2006. Call ELDER*info* at 1-800-336-9500 to find out or to receive counseling during this period.

Preventing Medicare Fraud

People with Medicare should keep their personal information safe. Don't give your information to anyone who comes to your home or calls you uninvited, selling Medicare-related products. They can only give you information about a plan, and can't ask you for your personal information or enroll you in a plan.

Only give personal information when you have made the contact. For example, if you call or visit the websites of plans that are approved by Medicare; if you call or visit people in the community who work with Medicare, like your State Health Insurance Assistance Program or the Social Security Administration; or if you call 1-800-MEDICARE or visit www.medicare.gov on the web.

People who are really working with Medicare won't try to enroll you into a drug plan over the telephone unless you call them, or unless you are already in a Medicare Advantage Plan and they call to ask if you would like to add prescription drug coverage to the coverage you already have.

Call 1-800-MEDICARE if you aren't sure if a plan is approved by Medicare. Plans are allowed to mail information and to call you. They aren't allowed to sell plans door-to-door.

If you think someone is misusing your personal information, call 1-800-MEDICARE (TTY users should call 1-877-486-2048) or the Fraud Hotline of the HHS Office of the Inspector General at 1-800-447-8477 (TTY 1-800-377-4950) or the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 (TTY 1-866-653-4261) to make a report.

Insurance Fraud

Many frauds and crimes are committed against senior citizens, including insurance-related fraud. To help protect against insurance fraud, follow these simple rules:

- When buying insurance or obtaining any services, remember, if it seems too good to be true, it probably is.
- When dealing with an agent you do not know, ask for identification and call the Insurance Commissioner's Office at 1-800-282-8611 or go to www.state.de.us/inscom to verify the agent's status, as well as the agency or insurance company the agent represents.
- If an agent selling you insurance or handling your insurance claim is reluctant to answer your questions, contact the Insurance Commissioner's Office.
- Never sign a blank form or pay in cash.
- Always make your checks or money orders payable to the insurance company.

If you have questions or if you need to report insurance fraud to the Delaware Fraud Prevention Bureau, please call 1-800-632-5154.

About Long-Term Care Insurance

Long-term care is a general term that includes a wide range of services providing assistance with health, medical, personal care, and social needs of people with chronic or prolonged illnesses, disabilities, and cognitive disorders, such as Alzheimer's disease. These services are typically required by the elderly, but may also be used by disabled people of any age.

Types of long-term care include:

- Personal care or custodial care for people who only need help with activities of daily living, such as eating, bathing, dressing or taking medication.
- Skilled care that is generally provided in a nursing home by licensed medical personnel under physician's orders, but may also be provided at home with help from visiting nurses or therapists.

Long-term care can be expensive depending on the amount and type of care needed and where it is received. On average, a year in a nursing home costs approximately $56,000. Home care, which can include part-time skilled nursing care, speech therapy, physical therapy and other services can easily cost $19,000 a year, while personal care provided at home by a home health aide costs approximately $11,000 per year.

Payment methods for long-term care vary and can include:

- Medicare will cover an approved skilled nursing facility on an extremely limited basis. The skilled nursing facility benefit only covers you if a medical professional says you need daily skilled care after you have been in the hospital for at least 3 days. You should not rely on Medicare to pay your long-term care needs.
- Long-term care insurance will pay for some or all of your long-term care. It may consist of an individual policy or group coverage. Benefits can cover a wide range of services.
- Self-funding, which means paying for care with personal or family money, pensions, savings, or investments.
- Medicaid pays for nearly half of all nursing home care. You must meet federal and state guidelines for income and assets to qualify.

Long-term care insurance is not a good buy for everyone. If you have significant assets you wish to protect and income that will allow you to pay premiums without financial difficulty, long-term care insurance may be right for you. However, if you have a limited income or have trouble stretching your income to meet financial obligations, such as paying rent, utilities, food, or medicine, you probably should not buy a policy.

People with very limited income and assets may qualify for Medicaid's Long-Term Care Services Program. The decision to purchase long-term care insurance will depend on your health, age, overall retirement objectives, and your income. You should discuss this purchase with a family member or financial advisor.

The "Shopper's Guide to Long-Term Care Insurance" which includes a policy comparison worksheet, is available from ELDER*info* at 1-800-336-9500.

Coverage: Like most insurance policies, the details of services covered and benefits paid will vary from policy to policy. However, state law requires that certain provisions be included in all long-term care insurance policies. Some of these provisions are:

- Coverage for all levels of nursing home care—skilled, intermediate, and custodial.
- Coverage for 12 months or longer.
- Policies must be guaranteed renewable. This means the company cannot cancel your policy for any reason except non-payment of

premiums or a misrepresentation on your application for coverage.

- No longer than a 6-month pre-existing condition exclusion.

- A 30-day "free look" period. You can return the policy for any reason during this time and receive a full refund.

- Benefits cannot be conditioned on a hospital stay prior to admission to a nursing home.

What Else Must Be Offered:

- The option to purchase inflation protection of at least 5 percent compounded annually. This feature will increase the benefits of your policy over time. Therefore, the younger you are when you buy a policy, the more important it is for you to consider adding inflation protection. Keep in mind that the cost of this additional benefit could add significantly to your premiums. If you decline to purchase inflation protection, you will be asked to sign a statement rejecting the coverage. Be sure you understand what you are signing.

- Third-party notification. To avoid a lapse of the policy for non-payment of premiums, companies must offer to notify a person in addition to yourself whom you designate of the impending lapse.

- The option to purchase a non-forfeiture benefit which will allow you to receive some value for the money you have paid into the policy should you have to drop your coverage. A non-forfeiture benefit can add roughly 10 percent to 100 percent to a policy's cost. If you decline to purchase this benefit, you will be asked to sign a statement rejecting the offer. If you reject the offer, the company is required to provide a "contingent benefit upon lapse." This benefit will take effect when your premiums increase to a certain level. You will then be offered the opportunity to accept: (1) a reduction in the benefits provided by the current policy so that premium costs stay the same; or (2) a conversion of the policy to paid-up status with a shorter benefit period. You may also choose to keep your policy and continue to pay the higher premium.

Federally Tax-Qualified Long-Term Care Insurance Policies: Under the Health Insurance and Portability Act of 1996 (HIPAA), long-term care insurance policies that met certain requirements became eligible for federal income tax advantages. These policies are now called "tax-qualified" long-term care insurance policies. You may be asked to choose between a "tax-qualified" plan and one that is "non tax-qualified." If you have a qualified long-term care policy and you itemize your deductions, you may be able to deduct part, or all, of the premium you pay for the policy. You may also be able to add the premium to your other deductible medical expenses. You may then be able to deduct the amount that is more than 7.5% of your adjusted gross income on your federal tax return. It is recommended that you contact your personal tax advisor for complete details before filing your return.

Long-Term Care Insurance Companies

Allianz Life Ins Co Of North America	1-800-950-1962	A
American Family Life Assurance Co	1-800-992-3522	A+
American General Life Ins Co	1-888-565-3769	A+
American Network Insurance Co	1-800-362-0700	B
American Progressive Life & Health	1-800-664-6494	B++
Bankers Life & Casualty Ins Co	1-800-621-3724	B++
Berkshire Life Ins Co Of America	1-888-505-8743	A+
Combined Ins Co Of America	1-800-544-5531	A
Conseco Health Ins Co	1-800-541-2254	B++
Conseco Senior Health Ins Co	1-800-441-3978	B
First-Penn Pacific Life Ins Co	1-800-323-1746	A+
Genworth (formerly GE Capital Assurance Co and GE Life & Annuity Assurance Co)	1-800-456-7766	A+
Golden Rule Ins Co	1-800-261-3361	A
Great American Life Ins Co	1-800-921-9338	A-
Guarantee Trust Life Ins Co	1-800-338-7452	B+
John Hancock Life Ins Co	1-800-377-7311	A++
Knights Of Columbus	1-800-214-9825	A++
Loyal American Life Ins Co	1-800-633-6752	A
Massachusetts Mutual Life Ins Co	1-888-505-8952	A++
Medamerica Insurance Co	1-800-544-0327	A-
Medico Life Ins Co	1-800-228-6080	C++
Metropolitan Life Ins Co (AARP)	1-800-452-1393	A+
Minnesota Life Insurance Company	1-888-505-9817	A+
Mutual Of Omaha Ins Co	1-800-775-6000	A
New York Life Ins Co	1-800-224-4582	A++
Northwestern Long-Term Care Ins Co	1-800-890-6704	A++
Penn Treaty Network America Ins Co	1-800-362-0700	B
Provident Life & Accident Ins Co	1-800-331-1538	A-
Prudential Ins Co Of America	1-800-732-0416	A+
Southwestern Life Ins Co	1-888-304-9200	A-
State Farm Mutual Automobile Ins Co	(302) 674-1158	A++
State Life Ins Co	1-888-505-8101	A
Teachers Ins & Annuity Assoc (TIAA)	1-800-223-1200	A++
United American Ins Co	1-800-825-6767	A+
United Security Assurance Co Of Pa	1-800-872-3044	B++
United Teacher Associates Inc Co	1-800-880-8824	A-
Unum Life Ins Co Of America	1-800-227-4165	A-
Woodmen Of The World/ Omaha Woodmen Life Ins Society	1-800-225-3108	A+

Rating Key

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A and A- = Excellent
B++ and B+ = Very Good
B and B- = Fair
C = Weak
NR = No Rating Available
u = Under review

Ratings are from A.M. Best Rating, an independent rating and information agency, and are accurate as of March 2006. For the most current rate information, please visit www.ambest.com.

ELDER*info*

1-800-336-9500

Health Insurance Counseling For People With Medicare

The Delaware Insurance Commissioner's **ELDER***info* program helps people with Medicare in Delaware deal with the complex and often confusing health insurance system.

ELDER*info* provides counseling and assistance on questions and problems related to Medicare, Medicaid, Medigap, long-term care insurance and other types of health insurance. There is no charge for this service.

Counselors with **ELDER***info* are volunteers who have completed extensive training on health insurance. Counselors provide one-on-one assistance in an objective and confidential manner.

Call 1-800-336-9500 to schedule an appointment with an **ELDER***info* counselor at a site near you.

To become an **ELDER***info* volunteer and help other Medicare beneficiaries understand their health insurance options, please call 1-800-336-9500.

ELDER*info* is Delaware's State Health Insurance Assistance Program (SHIP) and is funded in part by a grant from the Centers for Medicare and Medicaid Services.